BIOLA
UNIVERSITY

RELEASE AND INDEMNIFICATION AGREEMENT FOR MINORS

Biola Youth Academics Field Trip Permission Slip

(Please print neatly)

PARTICIPANT: (Name and Full Address) _____

_____

INSTITUTION: BIOLA UNIVERSITY, INC. DESCRIPTION OF ACTIVITY: _____

_____

_____

_____

LOCATION: _____ DATE(s): _____

I am the Parent/Guardian of the above-named Participant who is under eighteen years of age and am fully competent to sign this Agreement. I give permission for Participant to participate in the above-referenced Activity.

In consideration of Participant being permitted to participate in the Activity, I hereby accept all risk to Participant's health and of his/her injury or death that may result from such participation, including transportation to and from such Activity, and I hereby release the above named Institution, its governing board, officers, employees and representatives from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Activity, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity.

I entrust the care of the Participant to Biola University to act as my agent concerning the health care of the Participant, and to consent to any X-ray examination, anesthetic, and medical, dental or surgical diagnosis or treatment and hospital care to be rendered under the general or special supervision and advice of a physician or surgeon licensed under the provisions of the Medicine Practice Act; dentist licensed under the provisions of the Dental Practice Act; and the staff of any acute general hospital holding a current license to operate a hospital from the state of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care that the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the Participant, but that any of the above treatments will not be withheld if the undersigned cannot be reached. I agree to maintain health insurance covering the Participant during the period of participation in the Activity and to accept financial responsibility for any care to the Participant as described above. This authorization is given pursuant to Section 6910 of the Family Code of California and remains effective only for the Participant listed at the top of this document.

_____ _____

Medical Insurance Company Policy Number

_____ _____

Signature of Parent/Guardian of the above-named Participant Printed Name

_____

Full Address (if different than Participant's)

_____ _____

Date Signed Parent/Guardian Emergency Contact Numbers (include area codes)